GENERAL HEADQUARTERS
UNITED STATES ARMY FORCES, PACIFIC
OFFICE OF THE CHIEF SURGEON

A.P.O. 500
30 October 1945

CIRCULAR LETTER)
:
NO . . . . . 45)

Treatment of Clinical Malaria and
Malarial Parasitemia . . . . . Section I
Drug Suppressive Treatment of Malaria . Section II
Contraindications to the Use of
Atabrine . . . . . Section III

Technical Memorandum No. 6, Hq, USAFFE, Office of the Chief Surgeon, dated 12 May 1944, subject: "Treatment of Malaria", is rescinded.

I. Treatment of Malaria and Malarial Parasitemia. The treatment of attacks of clinical malaria and malarial parasitemia should be as directed in WD TB MED 72, dated 10 July 1944, subject: "Treatment of Clinical Malaria and Malarial Parasitemia". The treatment for uncomplicated malaria should be atabrine dihydrochloride 0.2 grams and sodium bicarbonate 1 gram by mouth with 200 to 300 cc of water every 6 hours for five doses, followed by atabrine 0.1 gram three times a day after meals for 6 days. If for any reason other treatment routines are used, the total dose of atabrine should not exceed 2.8 gms in seven days.

II. Drug Suppressive Treatment of Malaria. The administration of atabrine to suppress malaria should be as directed in Circular No. 95, paragraph 2 g, General Headquarters, United States Army Forces, Pacific, dated October 1945, subject: "Control of Malaria and Insect-borne Diseases" and the total suppressive dose should not exceed 0.7 gms. in seven days.

III. Contraindications to the Use of Atabrine.

a. Army experience indicates that atabrine is an extremely valuable drug in the control of malaria and side effects believed to be due to atabrine have never been of a magnitude sufficient to warrant abandoning the use of the drug except in a few individuals. True hypersensitivity to atabrine leading to exfoliative dermatitis is known to occur but it is very rare and is thought to be much less common than hypersensitivity to quinine.

b. The use of atabrine is related to the occurrence of "atypical lichen planus" and the aplastic anemia, agranulocytosis and exfoliative dermatitis that very rarely accompany it. All the factors concerned in the development of this condition are not known and the fact that it occurred almost never in some areas where atabrine was widely used leads to the belief that there are probably conditions other than the use of atabrine essential to its development. It appears that lichen planus and its accompaniments are more likely to occur in individuals taking larger doses of atabrine than those prescribed in Sections I and II of this circular.

c. Rarely psychological disturbances appear in individuals taking atabrine which bear much resemblance to the disturbances that sometimes accompany the administration of bromides.

d. Atabrine suppressive medications should be discontinued promptly and the drug should not be used for clinical treatment when individuals develop the following conditions:

1. Atypical lichen planus,

2. Unexplained chronic symmetrical eczematoid dermatoses,

3. Unexplained toxic erythematous eruptions,

4. Exfoliative dermatitis,

5. Severe leukopenia, agranulocytosis, and aplastic anemia,

6. Toxic psychoses which can be reasonable attributed to atabrine after careful clinical study.

e. Supplies of quinine are available for the treatment and suppression of malaria in those few patients who react unfavorably to atabrine but atabrine is believed to be the drug of choice unless untoward reactions contraindicate its use.

f. The records of patients thought to react unfavorably to atabrine should contain a prominent note of the fact so that they will not be forced to take atabrine subsequently.

g. Army worldwide experience in the use of atabrine indicates that it is a drug of great value and rare toxicity. Most early rumors regarding its dangers were without foundation. The list of contraindications to the use of atabrine enumerated in Section III (d) above contains all the known untoward effects which may attend its use. The rare occurrence of any of these effects is in striking contrast to the experience of thousands of troops who take atabrine over a period of several years with no more discomfort than that occasioned by transitory initial gastro-intestinal dysfunction. Knowledge of these facts is important and should be widely discussed among medical officers in order that a variety of vague discomforts or even more serious coincidental conditions will not be unjustly attributed to atabrine.

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for and in the absence of
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